Tri-Service Remote Dental Program

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Dental care for the remotely stationed **DoD Active Duty Service Member (ADSM)** is provided under the provisions of the Tri-Service Remote Dental Program (RDP) administered by the Military Medical Support Office (MMSO). Service members enrolled in TRICARE Prime Remote for medical coverage are automatically eligible for the Tri-Service Remote Dental Program. There is no preferred dental provider network, so treatment may be obtained from any licensed dentist in the fifty United States and District of Columbia. MMSO does not maintain a list of participating dentists. If the service member does not have an established dental provider, they may consider consulting the TRICARE Web site for the name of a TRICARE Dental Program participating dentist in their area. Please note that all dental pre-authorization requests, claims, and other inquiries should be sent to MMSO and not TRICARE.

ADSMs may contact the Military Medical Support Office Customer Service directly for specific eligibility information related to dental treatment. **DoD service members** may contact the MMSO at 1-888-MHS-MMSO (1-888-647-6676). **USPHS and NOAA members**, call the Beneficiary Medical Program at 1-800-368-2777 option 2. **Coast Guard members**, call 1-800-9HBA HBA (1-800-942-2422).

General Benefit Information:

For all procedures appropriately pre-authorized there is no deductible or co-payment required of the service member. In most cases, the RDP will pay the usual and customary fee the dental provider charges their private-pay patients and other third-party payment programs. The U.S. government reserves the right to establish a maximum allowance for any given procedure. Some procedures are not covered benefits (see sections on covered and non-covered procedures). Therefore pre-authorization of treatment is highly recommended.

The purpose of the Tri-Service Remote Dental Program (RDP) is to augment, not replace, dental care provided at active duty dental treatment facilities. All appropriate and

necessary treatment to establish and maintain dental health sufficient to meet worldwide readiness status will be considered for pre-authorization/payment. Procedures or treatment that will negatively impact worldwide readiness or deployability will be considered but is not likely to be authorized.

For extensive or questionable treatment plans, evaluation at an active duty dental treatment facility may be required before an authorization or denial for treatment is made. Every consideration is given to minimize travel and the service member's time away from the unit. Service members and their units share responsibility with the active duty military dental facilities for maintaining dental readiness. Military exams and needed dental care are expected to be kept up-to-date as part of this requirement. Treatment to correct a pre-existing condition (such as a missing tooth or a malocclusion) that is not presenting as an acute condition, nor is likely to create an acute condition, or is not immediately needed to meet occupational requirements or world-wide dental readiness status may be recommended to be delayed until the service member is able to receive this care at an active duty dental treatment facility.

Eligibility:

Service members enrolled in TRICARE Prime Remote (medical) are automatically eligible for the Tri-Service Remote Dental Program (RDP). RDP eligible active duty service members can receive emergency dental care any time they are in an active duty status (see definition and examples of emergency care). To be able to receive routine or specialty dental care through the RDP, the service member must be on continuous active duty status for more than 30 days. Once the service member separates from active duty they are no longer eligible for RDP benefits, including any treatment that may have been authorized or initiated while on active duty. Service members that are separating with transitional assistance (TA) health care benefits are entitled to limited dental coverage for emergency care only.

(Service members that have served 180 days of continuous active duty or more may be eligible for dental care as a Veteran's benefit following separation from active duty. The laws governing VA benefits change frequently. The service member should investigate their benefits through their local VA office. Call 1-800-827-1000 to obtain the telephone number of the nearest VA representative in all 50 states, Washington D.C. or Puerto Rico. Or visit the web site: http://www.cfda.gov/public/viewprog.asp?progid=778 .)

For more information on eligibility see the Military Medical Support Office information paper concerning Supplemental Health Care and TRICARE Prime Remote programs available on the MMSO Web site.

Emergency Dental Care:

Emergency care does not need pre-authorization. This includes any treatment necessary to relieve pain, treat infection, or control hemorrhage to include: temporary or permanent fillings, root canal treatment, extractions, or other immediate required treatment. Crowns, bridges, and dentures are not considered emergency care and require pre-authorization (see below).

For example, root canal therapy required to relieve pain or treat infection can be completed without pre-authorization even if this treatment requires more than one appointment. If a crown is indicated following the root canal therapy, the crown must have pre-authorization before initiating the crown preparation.

Other examples: If an anterior tooth fractures or a posterior tooth suffers a cuspal fracture, the tooth should be restored with a direct filling material to cover any exposed dentin and provide temporary treatment while written pre-authorization is obtained for a crown (if indicated).

If a posterior tooth suffers a central groove fracture, a temporary crown should be placed to stabilize the crack and allow follow up evaluation for possible root canal therapy while awaiting written pre-authorization for a crown. A separate charge will be paid for the temporary crown if the dentist providing the permanent crown is not the same dentist (or service corporation) that provided the temporary crown.

If a service member has an acute condition involving one impacted tooth requiring a surgical extraction, extraction of that tooth can be completed without written pre-authorization. Extraction of other non-emergent teeth requiring the same treatment should be delayed until written authorization is obtained.

Routine Dental Care:

Routine dental treatment can be completed without first obtaining pre-authorization, as long as the treatment meets all of the following requirements:

1. Routine care includes diagnostic (exams and X-rays), preventive (cleanings), routine restorations (amalgam or composite fillings), and single tooth extractions.
2. The total cost of the procedure or treatment appointment must be less than $500 to be considered routine care. For example, two or three fillings or extraction of one or two teeth is considered routine care as long as the total cost is less than $500 for that appointment.
3. Treatment plans that exceed a total of $1,500 per calendar year require pre-authorization, even if each of the procedures or treatment appointments is less than $500 per procedure/appointment.
4. The procedures must be covered benefits. (See the section on covered and non-covered procedures.)

Examples: If the total cost of any non-emergency treatment for any one procedure or appointment will exceed $500 (such as most multiple wisdom tooth extractions) you must have written pre-authorization from MMSO before initiating the treatment.

Note: All prosthodontic procedures, including single unit crowns, require written pre-authorization from MMSO, regardless of cost. All non-emergency surgical procedures are considered specialty care and require pre-authorization, regardless of cost.

Specialty Dental Care:

All specialty care (prosthodontics, periodontics, multiple extractions or other oral surgery) and other dental treatment not considered emergency or routine care requires pre-authorization. Initiating specialty care without written pre-authorization from MMSO may result in the service member being responsible for part or all cost of treatment. If the dental provider initiates specialty care without receiving written pre-authorization from MMSO, the provider has the responsibility to obtain written consent from the service member clearly explaining this financial responsibility and risk.

Covered procedures:

All procedures or treatments must meet the requirements of being appropriate and necessary to establish and maintain dental health to meet worldwide readiness/ deployment status.

Diagnostic Services:

Examinations and radiographs are covered as needed to effectively diagnosis and develop appropriate treatment plans. Two routine examinations per year are covered without obtaining pre-authorization. Oral examinations are considered integral when provided on the same date of service as palliative or surgical procedure(s) by the same dentist. Limited oral evaluations - problem focused, are only covered when performed on an emergency basis.

Additional examinations for specialty evaluations for covered procedures are authorized one per specialty per year. Note: Orthodontic and implant evaluations and related services are not covered.

Preventive Services:

Two routine prophylaxes are covered per year to establish and maintain dental health. If additional prophylaxes are indicated to control periodontal disease, the additional prophylaxes require pre-authorization. Note: Adult fluoride treatment is not covered unless pre-authorized as part of a specific caries control program. Sealants also require pre-authorized and the justification must be provided in the pre-authorization request.

Restorative Services:

Covered restorations not requiring pre-authorization are amalgam and composite resin restorations, provided they meet the financial limitations for routine care previously described. Multiple restorations performed on a single tooth will be paid as a single restoration reflecting the number of surfaces involved. Note: Following premolar or molar root canal therapy a cuspal coverage amalgam core buildup can be placed without pre-authorization (to provide both a core build-up for a future crown and protection from fracture.

Covered materials/procedures also include preformed or cast posts (as appropriate), core build-ups (both with and without retention pins), cast gold crowns, and porcelain-fused-to-metal crowns. Cast posts are limited to root canal treated anterior teeth. Preformed posts may be used in both anterior and posterior root canal treated teeth. (All of these procedures require pre-authorization.)

Substitution of a non-covered procedure for a covered procedure is not allowed. For instance: Pre-authorization is granted for a porcelain-fused-to-metal (PFM) crown. An all-ceramic crown may not be substituted for the PFM even if the cost is equal to, or less than, the cost of the authorized PFM crown. An exception would be the substitution of a direct restorative material for an authorized indirect restoration, but the billing will reflect the procedure actually provided in procedure code, description of code, and fee.

Endodontic Services:
Covered procedures include: pulpotomy (for emergency treatment when provided by a dentist not completing the root canal therapy), root canal therapy and endodontic surgery. Non-emergency endodontic surgery requires pre-authorization. Pulpotomies are considered integral when performed by the same dentist within 45 days prior to the completion of the root canal therapy.

Periodontal Services:
Covered services include: periodontal prophylaxis, scaling and root planning and periodontal surgery. Surgical procedures such as gingival curettage, gingivectomy or gingivoplasty, crown lengthening, grafting (both soft and hard tissue), and guided tissue regeneration require pre-authorization.

Oral Surgery Services:
Covered procedures include: extractions (routine, surgical, and impacted), tooth reimplantation and/or stabilization, alveoloplasty, and surgical treatment of abscesses. Analgesia, sedation, and general anesthesia are covered when used in conjunction with surgical procedures but written pre-authorization must be obtained unless the surgical procedure is for treatment of an emergent condition.

Removable and Fixed Prosthodontics:
Covered services include: repairs, relines and rebases to complete and partial dentures, complete and partial dentures, and fixed bridges. Cast gold and porcelain-fused-to-metal are the only materials/techniques currently authorized. All prosthodontic procedures require pre-authorization (with the exception of repairs to, or recementation of, existing prosthesis).

Again, substitution of one procedure for another is not authorized. The one exception would be the substitution of an all gold crown for an authorized PFM crown (but not vice-versa). All metal restorations are recommended in areas that are not an esthetic concern or where conservation of sound natural tooth structure is indicated.

What is not covered:
Experimental drugs or procedures are not covered.

Medications not prescribed in writing by an authorized health care provider are not covered. Over-the-counter prescriptions, even if prescribed in writing by an authorized health care provider, will not be authorized for payment or reimbursement.

Supplies for home use (toothbrushes, mouth rinses, and other over-the-counter personal hygiene supplies), even if recommended by the dentist, are not authorized for payment or reimbursement. These are the personal responsibility of the service member.

Plaque control program, oral hygiene, and dietary instructions are not covered.

Sealants and fluoride treatment for adult patients are not covered unless pre-authorized (see above).

Cosmetic treatment (bleaching, bonding, porcelain veneers, etc.) is not covered.

Porcelain or composite resin inlays/onlays, and gold foil restorations are not covered.

Composite resin or all-porcelain full or partial coverage crowns are not covered.

Duplicate or temporary devices, appliances, and services are not covered.

Civilian orthodontic treatment (braces) is not normally authorized. Exceptions may be granted in unusual circumstances but a general guideline is that correction of previously existing malocclusions is not covered.

Implants and related procedures and elective procedures such as replacement of serviceable crowns, bridges and other prosthesis may be delayed for evaluation and treatment at an active duty dental treatment facility (DTF). Repllacement of missing teeth not causing an acute condition and not likely to result in a deterioration of the dentition during the service member's tour at that duty station may also be delayed for evaluation and treatment at a DTF. Exceptions may be granted in unusual circumstances but a general guideline is replacement of serviceable prosthodontic restorations or non-essential missing teeth is not covered.

Separate charges for local anesthesia, infection control, bases, liners, indirect pulp cap, diagnostic casts, temporary crowns, photographs, etc., are considered integral to the parent (original and main) procedure, and will not be paid or reimbursed as an additional fee. Nor will these be charged to the service member.

Nitrous oxide analgesia, intravenous sedation, and general anesthesia are not covered in conjunction with routine operative or preventive procedures. Exceptions may be made in unusual circumstances but written pre-authorization is required for payment or reimbursement. Authorization for payment or reimbursement of analgesia, etc., used in conjunction with routine operative or preventive procedures will not be granted after-the-fact.

Charges for failure to keep a scheduled appointment, transportation costs related to outpatient treatment or charges for completion of a claim form are not covered.

What requires pre-authorization:

Extensive routine dental care or any procedure that does not fit the definition of emergency or routine dental care as previously described to include:

Surgical extractions of non-emergent impacted third molars (wisdom teeth) and any special surgery care to include non-emergent periodontal and endodontic surgery.

All crowns, bridges, complete and partial dentures, and other prosthodontic procedures, including all partial coverage or full coverage gold and porcelain-fused-to-metal restorations.

Nitrous oxide analgesia, intravenous sedation, and general anesthesia in conjunction with non-emergency dental treatment.

Procedure for Requesting Dental Pre-Authorization:

To request pre-authorization for dental care, the service member's unit forwards written correspondence and supporting documentation to the MMSO. The submission should include (at a minimum):

1. A Command Request Memorandum from the service member's unit signed by the unit commander or designated medical program representative. See the MMSO Web site for a sample letter.
2. A treatment plan from the dental provider indicating (as appropriate) tooth number, ADA procedure code and description of procedure, and an itemized fee for each procedure.
3. Appropriate current diagnostic-quality radiographs. All requests for crowns should include both bitewing and periapical radiographs. All requests for bridges, partials and dentures should include current full mouth radiographs or panoramic x-ray documenting all missing and remaining teeth and appropriate diagnostic-quality periapical radiographs of the proposed abutment teeth identified in the treatment plan.
4. Any additional information (photographs, narrative justification, dates of previous placement of crowns, bridges, other prosthesis if the request is for replacement of existing prosthesis) that may be useful to justify the need for the requested treatment.

All of the information should be mailed (not faxed) to:

The Military Medical Support Office
Attention: Dental Pre-authorizations
P.O. Box 886999
Great Lakes, Illinois 60088-6999

Return correspondence will be sent to the unit address supplied on the Command Memorandum. The MMSO return correspondence will provide clear authorization or denial of the requested treatment with the authorized fee and a control number assigned to all authorizations. All denials will be supplied a reason and possibly a recommended alternative treatment. MMSO's pre-authorization determination is made exclusively on the documentation provided so clarity and completeness of the request is critical. Be

certain to provide complete correct mailing information. Dental x-rays (and photographs) will be returned to the same address. Study models (if sent) will not be returned. Keep a copy of your request information.

The service member's failure to obtain required pre-authorizations may result in personal financial liability. When in doubt about pre-authorization requirements, service members should refer to the MMSO Web site or submit the request for treatment to the MMSO for review.

Procedure for Filing Claims:

Claims should be submitted within 90 days of date of service. Items required for processing a claim:

1. A completed standard American Dental Association (ADA) Dental Claim Form identifying (as appropriate) the tooth number, ADA procedure code, description of procedure, date of service, and itemized cost of each procedure performed by the dental provider.
2. A completed MMSO Dental Information Sheet (available on the Web site) signed by the service member or the designated representative of the service member's military unit.

Send this information to:

The Military Medical Support Office
Attention: Dental Claims
P.O. Box 886999
Great Lakes, Illinois 60088-6999

Upon receipt of complete claim information, the MMSO will process the claim. If the service member has paid out-of-pocket expenses for dental care, a Claim for Reimbursement for Expenditures on Official Business (SF 1164) signed by the service member accompanied with appropriate proof of payment must be submitted with the forms described above.

The claim will be paid by U.S. Treasury check, usually within 30 days. An Explanation of Benefit (EOB) will be sent to both dental provider and service member at the addresses indicated on the dental claim form or MMSO Dental Information Sheet.

The service member is responsible for notifying his/her command of all dental care received. The service member is also responsible for ensuring that the claim has been submitted with the required information and that the claim has been paid. Failure to ensure the claim has been submitted promptly and appropriately may result in credit problems or even personal financial liability to the service member. If a claim is denied because the MMSO does not yet have eligibility verification or other information required to process the claim, it does not mean these services will not be covered. However, until the required information is supplied, the MMSO will not be able to

process the claim. To check on the status of a submitted claim or if assistance is required contact the MMSO at 1-888-647-6676.

Appeal Process:

If the MMSO denies a claim or written request for pre-authorization, the member or member's command will be notified in writing. The member or member's command may mail or send a facsimile letter with additional information to the MMSO as a first level appeal. Subsequent levels in the appeal process may overrule the previous decision in whole or in part. Appeals must be made in the following sequence:

First Level: Officer in Charge, Military Medical Support Office, P.O. Box 886999, Great Lakes, Illinois 60088-6999. FAX: DSN 792-3905, or (847) 688-3905.

Final Level: Surgeon General for the service member's Branch of Service.

Contact Information:

Instructions and forms, as well as other information may be found on the MMSO Web site at: http://mmso.med.navy.mil. The MMSO may be contacted at 1-888-MHS-MMSO (888-647-6676) for general information or questions pertaining to claim processing or status of a claim.